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OAK TERRACE HEALTHCARE CENTER	1750 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Annual Certification Survey Federal Oversight and Support Survey Complaint #1643667/IL86672 Statement of licensure violations	S 000		
S9999	Final Observations Licensure 1 of 3 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	**Attachment A** **Statement of Licensure Violations**	

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide safe transfer techniques, assess and identify causative factors contributing to falls and injuries, implement progressive interventions and monitor and modify those interventions as necessary to prevent falls and injuries for five of 12 residents (R1, R2, R5, R6 and R10) reviewed for falls and injuries in the sample of 12 and 5 residents (R14, R16, R20,

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R21 and R23) in the supplemental sample. This failure resulted in R16 sustaining a dislocated shoulder during a transfer requiring a post reduction to surgically restore the dislocation and R23 sustaining a fracture rib.

Findings include:

1. R16's Nurse's Note, dated 03/03/16, documented E13 and E14, Certified Nurses Aides (CNAs) were transferring R16 from the shower chair to the wheelchair. The Nurse's Note documented "(E13) stated that the (mechanical lift) would not fit into the bathroom, so one aide got on each side to transfer resident. (E13) heard a pop and (R16) was not able to perform Range Of Motion (ROM) on right arm." It further documented, "(R16) sent to emergency department for evaluation."

On 03/04/16, a Cat Scan (CT) report documented, "Anterior displacement of the humeral component of the right reverse shoulder arthroplasty. There does appear to be superior subluxation of the clavicle relative to the acromion." Also, a post reduction to surgically restore the dislocation to the correct alignment was performed on R16 03/04/16.

On 03/04/16 at 5:30 AM, R16's Nurse's Note documented R16 returned from the hospital after a post reduction of the right shoulder prosthesis.

E13's written statement, dated 3/3/16, documented "We were getting the resident (R16) out of the shower chair and there was not no room." E13 documented, "I had her right arm and leg and (E14) had her left arm and leg. It was very up close and personal, but as we sat her bottom down she was just to the chair and I'm

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sure I heard a crack in her arm or something. She said it didn't hurt but she couldn't move it."

E14's written statement, dated 3/3/16, documented "I wasn't the shower person and she (E13) said 'Hey come help me, I normally use the (mechanical lift).' We couldn't fit the (mechanical lift) in the bathroom. (E13) just said come and help me and we asked (R16) how they were doing her, she said just lifting her. So, I just helped her cause she asked. I didn't know I could use the sit to stand. Didn't remember about the Kardexs."

R16's Nurse's Note, undated, documented "Aides used a fireman's technique because the 200 shower room was under temporary construction and the (mechanical lift) would not fit in the 100 hall shower room."

R16's Physician's Order Sheet (POS), dated 01/29/16, documented R16 had the following diagnoses, in part as, Cerebrovascular Accident (CVA) with Right Side Hemiplegia and Hemiparesis, Muscle Weakness, Parkinson's Disease, Cerebral Palsy and history of Right Shoulder Rotator Cuff repair.

On 01/29/16, the Admit/Readmit Screener (Initial Nursing Assessment) documented R16 was total dependence for transfers.

R16's Minimum Data Set (MDS), dated 02/01/16, documented R16 was moderately cognitively impaired and required extensive assistance of two staff for transfers and had ROM limitations of bilateral upper and lower extremities.

The Care Plan, dated 02/07/16, documented R16 required mechanical lift with two staff for

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transfers. Also, documented R16 was a high fall risk related to Parkinson's Disease and Cerebral Palsy. On 02/24/16, Care Plan was updated documenting R16 required a mechanical lift or sit to stand (dependent on resident mobility at time of transfer) with two staff for transfers.

On 06/29/16 at 3:25 PM, E2, Director of Nursing (DON) stated that E18, MDS/Care Plan Coordinator had added the sit to stand transfer as a courtesy to R16 because R16 wanted to go back to an assisted living facility and could not go unless she could be transferred via sit to stand. E2 stated that there were no assessments done to determine if a sit to stand transfer was appropriate or safe for R16. E2 also stated that R16 was not in therapy or on restorative for transfers.

On 06/29/16 at 2:15 PM, E14 stated that she was asked to help E13 to transfer R16 from the wheelchair to the shower chair. She stated that there were three CNAs that helped to transfer R16 from the wheelchair to the shower chair. She stated that they used a fireman-like transfer to lift the resident out of the wheelchair. She stated that R16 was only able to minimally bear weight on one leg, and really couldn't bear weight at all that day. E14 also stated that R16 was a larger woman and it took all three to get her into the shower chair. E14 then stated that she was asked again by E13 to transfer R16 from the shower chair to the wheelchair, but it was only the two of them. She said the shower room was very small and difficult to move around in. She stated that when they sat her down in the wheelchair E13 stated she heard a crack from R16's shoulder area. E14 stated the right arm was the more weakened side for R16 and could not move it at all after the cracking sound. E14 stated that she

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did not know about the Kardex for R16, did not know how R16 was to be transferred and did not use a gait belt. E14 further stated that she was educated after this incident on how R16 was to be transferred and said it was mechanical lift only.

The facility had no documentation that any staff were inserviced on transfer techniques safety or the Kardex system. The Kardex system is a card kept on each resident regarding basic care issues such as how each resident should be transferred.

On 6/29/16, at 10:15 AM, E2 stated that she had not done any in-servicing or training with staff of any kind, especially for Kardex system or transfer training. E2 further stated that each CNA should know about the Kardex's on each resident and that the nurses should be updating them as changes occur. E2 also stated that she had not updated any of the Kardexs for any of the residents living in the facility since she was hired in January 2016.

On 7/1/16, E19, CNA at 3:20 PM, E21, CNA at 3:30 PM, E22 at 3:40 PM, all stated they have not been trained on transfers, gait belts or falls. E20, LPN, was interviewed at 3:25 PM and also stated she has had no in-service training on transfers, gait belts or falls.

2. On 06/30/16 at 3:20 PM, R21 was sitting on a couch in the TV room with his wheeled walker by him. At 3:30 PM, R21 was ambulating with his wheeled walker. He passed by E25, Activity Aide, E19, E21 and E22 (CNAs), E23, LPN and E20, Registered Nurse (RN) without being noticed or assisted and continued down the 200 hall unassisted.

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On 7/1/16, at 3:20 PM, E19, stated R21 was a one assist for transfers. At 3:25 PM , E20 stated R21 was an assist with one staff for transfers and ambulation. At 3:30 PM, E21 stated R21 required one person physical assistance for transfers and ambulation. At 3:40 PM, E22 stated R21 required one person physical assistance for transfers and ambulation.

The POS, dated 06/01/16, documented R21 had the following diagnoses, in part as, Dementia without Behavioral Disturbances, Chronic Deep Vein Thrombosis of right lower leg, Osteoarthritis, Alzheimer's disease and restlessness and agitation.

R21's MDS, dated 05/08/16, documented R21 was severely cognitively impaired, scoring zero on the Brief Interview for Mental Status (BIMS). It also documented R21 required limited assist of one staff for transfers, dressing and bed mobility. It documented R21 required extensive assist of one staff for hygiene and bathing. Also, it documented R21 was frequently incontinent of both bowel and bladder and had ROM limitations on one side for both upper and lower extremities. The MDS documented R21 was not currently receiving any therapy or restorative services.

The Morse Fall Scale, dated 05/02/16, documented R21 was a high risk for falling.

R21's Care Plan, dated 01/09/16, documented R21 was identified as being a fall risk related to confusion and incontinence and under Activities of Daily Living interventions for Transfers "Resident uses walker to maximize independence with transferring." Other interventions were to anticipate residents needs and call light within reach, however identified R21 as having impaired

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cognitive function related to Dementia and Alzheimer's Disease. It also documented R21 had actual falls on 10/24/15, 12/08/15, 12/12/15, 02/18/16 and 04/03/16. There were no new interventions listed on the Care Plan after each fall.

The Kardex documented R21 was incontinent and required limited assist of one. It also documented R21 will void on the floor in the closet and have a bowel movement on the floor. It also documented R21 required supervision with ambulation and was independent with positioning with supervision.

The Post Fall Management Quality Assurance Form, dated 02/18/16 at 2:50 PM, documented R21 was found in the TV room with his pants down around his ankles attempting to toilet himself and lost balance and fell. No injuries documented. The intervention was that R21's dose of Olanzapine had been reduced on 02/17/16 and to monitor R21 over the weekend for any behaviors. No new interventions for the fall or toileting.

The Post Fall Management Quality Assurance Form, dated 02/18/16 at 9:00 PM, documented R21 "Appears to have hit the night stand in his room." It documented R21 had two skin tears on the left elbow measuring 2.2 cm x 0.9 cm and 0.9 cm x 1.5 cm. There was no documentation of any explanation if R21 was walking or in his wheelchair at the time of the incident. No new interventions were listed.

The Post Fall Management Quality Assurance Form, dated 04/03/16 at 5:30 AM, documented R21 was found on the floor in front of his bed with the floor wet with urine. No documentation of the

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bed alarm sounding. It documented R21 sustained a right elbow skin tear. No measurements recorded. It documented R21 was sent to the emergency department for evaluation and returned later to the facility. The interventions documented for R21 were every two hour checks while in bed related to toileting needs. There was no documentation that every two hour checks were completed by staff during or after this intervention was put into place.

The Post Fall Management Quality Assurance Form, dated 05/07/16 at 9:38 PM, documented R21 was found on the floor in the 300 hall lying on the carpeted floor on his right side knees bent with head resting on right arm sleeping. No documentation of the bed alarm sounding. No injuries were listed and unknown how long resident was there, because R21 ambulated without assist and there was no documentation that every two hour bed checks were done. Also, the 300 hall was vacant with no residents or staff attending that hall and was dark with no lights on. It documented R21 was assisted back to bed.

The Post Fall Management Quality Assurance Form, dated 05/20/16 at 10:00 AM, documented R21 was found sitting on the toilet in his room with a discoloration on top of the left shoulder. It was documented as being reddened bruising measuring 8 cm x 3 cm. Slight grimacing when ROM performed. No documentation of how resident got to the bathroom or that the bed alarm was sounding. It documented R21 has poor safety awareness with frequent bumps into things during ambulation. Alarm remains while in bed. The intervention listed was to encourage R21 to allow staff to assist when ambulating as long as he does not become agitated.

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The Post Fall Management Quality Assurance Form, dated 06/14/16 at 7:57 PM, documented R21 was found in bed with multiple blue/black bruises to the right and left forearms. It documented the right forearm measured 6 cm x 6 cm and there were three on the left forearm one measured 2.5 cm x 2.5 cm, one measured 2 cm x 1 cm and one measured 3 cm x 1 cm. It documented "Resident walks unsupervised and bumps things often." There were no new interventions documented on the form.

The Post Fall Management Quality Assurance Form, dated 06/25/16 at 11:30 PM, documented R21 was found on the floor in his room, bed alarm was sounding. It documented R21 complained of knee pain. It documented the "Because Factor/Conclusion" was "Resident may have got tired and laid down." There were no new interventions documented on the Quality Assurance Form or Care Plan.

The Post Fall Management Quality Assurance Form, dated 06/29/16 a 9:16 PM, documented R21 was witnessed by E23, LPN entering the shower room with his walker. When she got into the shower room she witnessed R21 let go of his walker and turn to come out of the shower room, lost his balance and fell backwards landing on bottom while both upper extremities struck the wall resulting in multiple skin tears. One skin tear on the left second finger, one on the right third finger and one on the right elbow. It documented that R21 claimed he was ready for bed, continued with confused conversation which is his normal baseline. The "Because Factor/Conclusion" was "Resident likely confused due to room change, may try bed alarm until resident put back to old room near nurses station." There were no new interventions documented on the form.

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3. On 06/21/16 at 1:30 PM, E2 and E23, LPN transferred R2 from the wheelchair to the toilet. E2 and E23 placed their arms underneath R2's axillas and lifting her by the gait belt while R2's feet never touched the floor. R2 became upset, anxious and agitated during the transfer and after. R2 was transferred in the same manner with her pants and incontinent brief at her ankles from the toilet to the wheelchair and again from the wheelchair to the bed. By this time, R2 was very anxious and agitated. At no time did R2's feet touch the floor during the transfers.
The POS, dated 06/01-30/16, documented R2 had the following diagnoses, in part as, muscle weakness, Alzheimer's Disease, Dementia with Behavioral Disturbances, history of Fall, Anxiety Disorder and Pseudobulbar Affect.
The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with short and long term memory deficits. R2's MDS documented R2 required total assistance of at least one staff for bed mobility, transfer, locomotion, dressing, eating, hygiene and bathing. It documented R2 required total assistance of two staff for toileting. It documented R2 had limited ROM in both upper and lower extremities and was frequently incontinent of both bowel and bladder.
The Morse Fall Scale, dated 04/16/16, documented R2 scored 75 points indicating a high risk for falls.
The Care Plan, dated 04/14/16, documented R2 was dependent on staff due to cognitive deficits. It documented R2 was identified as being totally dependent on at least one staff for all Activities of Daily Living (ADL's). It also documented R2 was identified of being high risk for falls.

4. On 06/22/16 at 9:15 AM, R20 was at a table in the dining room and had just finished eating

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with assistance of staff. Staff members were observed to be taking other residents to their rooms or the TV room. R20 was observed to stand up from her wheelchair, personal alarm sounded and staff intervened quickly and assisted R20 to her seat.
The POS, dated 06/01-30/16, documented R20 had the following diagnoses, in part as, Pseudobulbar Affect, Restlessness and Agitation, Anxiety Disorder, Abnormal Gait, Muscle Wasting and Atrophy, Toxic Encephalopathy, Disorientation and Non-traumatic Subdural Hemorrhage.
The MDS, dated 04/18/16, documented R20 was severely cognitively impaired. R20's MDS documents R20 required extensive assistance of one staff for bed mobility, transfers, dressing, eating and toileting. It also documented R20 required total assistance of one staff for hygiene and bathing, was frequently incontinent of bowel and bladder and had limitations in ROM in both the upper and lower extremities. It documented R20 is not participating in any therapy or restorative programs.
The Morse Fall Scale, dated 04/18/16, documented R20 scored 75 points indicating a high risk for falls.
The Care Plan, dated 01/22/16, documented R20 had impaired cognition with short and long term memory loss and required extensive assist of one staff to move between surfaces. It also documented R20 was identified as being high risk for falls related to gait/balance problems. It also documented R20 was identified as being restless, anxious and fidgety related to anxiety. It documented R20 was identified as having potential impairment to skin integrity related to fragile skin, decreased mobility and incontinence.
On 02/17/16 at 3:15 PM, the Report of Incident Situation Background Assessment

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Recommendation (SBAR) documented E9, CNA, was giving R20 a shower and noted bruising underneath both of R20's breasts. It documented R20 had fragile skin, poor safety awareness and that this was as a result of accidental or unintentional injury during transfer. The description was documented as a purple/yellow in color measuring 38.1 cm x 3.5 cm. The interventions were listed as " place gait belt appropriately, monitor bruise and transfer carefully."
On 02/16/16, E28, CNA, documented on a shower sheet that he observed bruising to bilateral breasts/ribs area and was signed by E16, LPN.
On 02/17/16, the Reportable Incident Report, written by E2 documented that upon investigation, the bruise was noted to be consistent with improper gait belt usage. During this investigation, E2 documented that on 02/13/16, E27, CNA stated that she had noticed the bruising at approximately 7:30 PM, but failed to notify the nurse because she thought they already knew about it. The Investigation documented that all nursing staff would be in-services on proper placement of gait belts. The Investigation did not document that transfer technique with a gait belt was discussed during this in-service.
On 7/5/16, at E16, LPN 1:15 PM, she confirmed she observed R20 on 2/17/16 with bruising under both her breasts

5. On 6/23/16 at 11:10 A.M., E11 and E17, CNAs, brought the sit to stand lift into R6's room. R6 was unable to grasp the sit to stand with her right hand. E17 stated "The last time before she fell, she could not hold on to the lift. I don't think we should use it." R6 was then pushed into the bathroom. E11 placed gait belt around R6's waist. E11 and E17 stood in front of R6 and

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undid R6's incontinent brief. E11 and E17 placed a gait belt around R6's waist. E11 and E17 lifted R6 by the gait belt and all of R6's weight was suspended on the gait belt since R6 could not bear weight on her feet. R6 was urinating on the floor during the transfer.

R6's clinical record documents that R6 has a history of falls.

R6's Progress Note, dated 6/10/16, at 1900, documents that "(R6) was found lying on right side, beside bed, knees bent, swelling present upper forehead 4 Centimeters (Cm) x 0.5 CM laceration in center of swelling. 5 CM x 0.5 CM laceration posterior scalp right side. Light pressure applied with dressing. Resident can move all without pain. Order received to send to hospital for evaluation and treatment." The Hospital Emergency Room Discharge, dated 6/11/16, documents R6 received staples due to a head injury.

The facility's incident review notes, dated 6/16/16, documents that R6 "appears to have hit head on nightstand when she rolled from bed. Nightstand is no longer next to the bed. It has been moved to the closet."

R6's Care Plan, dated 4/7/16, was not updated to address R6's nightstand being moved.

Throughout the survey, from 6/18 through 7/1/16 at 11:15 AM, R6's nightstand remained next to her bed.

R6's MDS, dated 4/5/16, documents that R6 is totally dependant and requires two plus physical assistance with bed mobility. The MDS documents that R6 is totally dependant, and

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requires one plus physical assistance for transfers. R6's Morse Fall Scale, dated 4/7/16, documents that R6 has a score of 65 (High risk is 45 and higher). R6's MDS documents that R6 has a diagnosis of Alzheimer's Disease, Restlessness and Agitation, Insomnia and Dementia.

R6's Care Plan, dated 4/7/16 , documents that R6 requires mechanical lift sit to stand with 2 staff assistance for transfers. R6's Care Plan documents R6 is at high risk for falls. R6's Care Plan documents under interventions that the facility will review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter, remove any potential causes if possible. Educate Resident/family/caregivers/Interdisciplinary team (IDT) as to cause.

The facility's Assessment of Fall Potential, dated 9/22/15, documents that R6 has a score of 14. (Score above 8 is high risk and should be at risk for potential falls).

The Kardex, a sheet of paper for each resident that provides CNAs basic instructions for care was in a binder on the 200 hall. R6's Kardex is undated and fails to include any specifics towards transfers except that she does use a recliner chair and one assist.

On 6/29/16 at 1:28 P.M., E9, CNA stated that she started employment at the facility in January. E9 stated that during orientation she was told what type of lift or transfer was needed for each resident. E9 stated that the Director of Nursing (DON) trained her on the use of a gait belt. E9 stated the training consisted of E9 demonstrating the use of a gait belt on the DON.

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On 6/29/16 at 1:25 P.M. E12, CNA stated that she had training on gait belts and transfers when she employment at the facility three months ago. E12 stated that the DON walked her around the facility and showed her how to do things.

6. The facility's Resident Incident Report dated 12/3/15, documents that R23 was found on the floor In his room. The facility's Investigation Conclusion dated 12/3/15, documents that R23 had a history of falling at home and from one fall had sustained an orbital fracture.
R23's Care Plan dated 1/7/16, documents that R23 is a high risk for falls. R23's Care Plan documents that staff are to anticipate and meet R23's needs, be sure R23's call light is within reach and encourage R23 to use it for assistance as needed, R23 needs prompt response to all requests for assistance and R23 uses bed and body alarm.
R23's Morse Fall Scale dated, 1/19/16, documents that R23 has a score of 75, which indicates R23 is at a high risk for falls. R23's Morse Fall Scale, dated 4/22/16, also documents a score of 75.
The Facility's Resident Incident Report dated 2/4/16 documented at 4:45 PM, R23 was found lying on his back on the floor in his room. The Report documented there was feces on the floor and his pants. The Post Fall Management QA form documents the root cause of the falls as he was incontinent of bowel and attempted to provide self care without assistance. The interventions was to place a floor mat next to his bed. R23's Care Plan was not revised with these new interventions.
R23's MDS, dated 4/18/16, documents that R23 has a Brief Interview of Mental Status (BIMS) of 3, which indicates R23 is severely cognitively

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impaired. R23's MDS documents that R23 has a diagnosis of Non Alzheimer's Dementia and Depression. R23's MDS documents that R23 requires assistance and 2 plus persons physical assistance for transfers and extensive assistance and 2 plus persons physical assistance for ambulation in his room. R23's MDS documented that under balance during transfers when moving from a seated to a standing position R23 is not steady and only able to stabilize with staff assistance.
On 7/1/16 at 3:10 P.M., E23, LPN, stated that in the middle of shift report on 6/30/16, E7, Restorative CNA, yelled from R23's room for help. E23 stated that when she entered the room R23 was lying on his back a distance from the bed. E23 stated that R23's lip was bleeding, and there was an area to right elbow skin tear. E23 stated that later R23 was complaining of his right side hurting, and that when she touched R23's right side he would flinch. E23 stated that she notified the physician and he ordered an X-ray. R23's x-ray report dated 6/30/16 at 8:18 P.M. documents that R23 sustained an acute non-displaced right lateral 8th rib fracture.
The facility's Management Incident Investigation Form dated 7/1/16, documents that R23 may have tripped on floor mat, and bed alarm sounding.

7. The MDS dated 4/18/16 documents R14 as requiring total assist of two staff for bed and extensive assist of two for transfer. The MDS documents R14 has severe cognitive impairment. The MDS documents R14's balance to have deficits with only able to move from place to place with the assistance of staff to stabilize.

R14's Care Plan, dated 4/18/16 documents R14 to be at high risk for falls due to vision problems,

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decreased mobility and cognition. The Goal is to be free of injury through next review with interventions being - "anti-tippers on w/c (wheelchair), anticipate and meet needs, call light within reach, bring to nursing station if unable to redirect or not ready for bed, education resident/family/caregivers about safety reminders and what to do if fall occurs, follow policy, lap buddy while up in w/c - release every two hours and PRN (as needed) for toileting, Review information on past falls and attempt to determine cause of fall, record possible root causes, schedule toileting between 3-4 am, bed/chair alarm - ensure in place, verbal reminders to not lean forward too far for items out of reach, wedge cushion."

Report of Incident Situation Background assessment Recommendation (SBAR) - Physical Injury report documents R14 to have multiple falls. On 1/30/16 at 9:10 AM, R14 fell in the dining room. The report documents R14 leaned too far forward in the wheelchair and "toppled out and landed on her lt (left) side." The report fails to identify whether the wedge cushion was in place but did document the alarm was sounding when she fell. The possible interventions checked include anti-tippers to the front of the wheelchair but no evidence that they assessed for adequate supervision. Root cause is identified as poor safety awareness.

A Report documented on 3/31/16 at 6:15 AM, R14 was reaching for the ice cart while in the wheelchair and CNA observed her falling to the floor on her left side. The report states the fall was witnessed in the hallway by the CNA who was unable to get to her in time to prevent the fall. Injuries were documented as a 2 centimeter (cm) x 1.5 cm skin tear to her left elbow and a 2

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cm hematoma on the top of her head. Intervention added was to give her a magazine or her purse early am to keep her busy. There is no evidence that R14 had the wedge cushion in her chair at the time. The Report documented only "verbal reminders not to lean forward too far" as interventions. Conclusion was "poor safety awareness." There is no documentation or assessment that the facility looked at adequate supervision since the CNA was unable to reach R14 before she fell or her cognitive impairment to process verbal reminders to not lean forward.

Incident Reports document R14 had two falls on 4/22/16. The Incident Report documents the first fall occurred in her room at 4:50 AM when she "was bending over in the chair fell out hitting her left side of her head first then her knee. Alarm was sounding." the Report documents the fall was witnessed by E15, LPN. E15's Progress Note, dated 4/22/16 at 4:50 AM, documented R14 sustained "a bruised lump to left temple with a 3 cm cut, cleansed with wound wash and steri stripped. Left knee with a 5 cm cut cleansed with wound cleanser and steri stripped." The investigation documents R14 is not able to follow directions, has decreased energy, poor coordination/unsteady gait, decreased strength and confusion. No new interventions were documented as put in place following this fall. At 7:10 AM, on 4/22/16, the progress notes document "Resident propelling herself around facility with wander guard & chair alarm on was bending over like she was reaching for something on the floor fell head first hitting her head on left temple & her left shoulder onto the hallway door. CNA called for writer who examined for injuries & initiated a neuro check. Resident lethargic, slow to answer questions & complaint of head & left shoulder pain. CNA placed towel under residents

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head. Writer left resident in floor not moving her for preventative of further injury until ambulance arrives." R14 was transferred to the emergency room for evaluation and treatment. The report documents R14 removed her lap buddy.
The progress notes documented R14 returned to the facility on 4/22/16 at 1700 (5:00 PM) and had "a large bruise area around left eye orbit, resident can open eye fine. Lacerations/skin tear above left eye is steri stripped - 7 cm (centimeter) x 8 cm, left knee scraped 4 cm x 4 cm."

The Investigation Record for the 4/22/16 identifies interventions as a lap buddy, restraint assessment, restorative assessment as added due to "poor trunk control, leaning over in w/c." The investigation identifies R14 as confused, impaired memory but does identify R14 as being able to maintain sitting balance. There was no documentation in R14's record that R14's Care Plan or Kardex was updated and a restorative assessment was completed as recommended .

Progress notes also documents ob 4/22/17 at 21:41 (9:41 PM) that R14 "continues to remove lap buddy after putting lap buddy on." Progress notes dated 4/27/16 at 20:40 (8:40 PM) documents R14 continues to try and stand up from wheelchair, and fidget with lap buddy, reassurance given frequently" and "attempts to reorient not successful." On 4/28/16 at 8:24 PM, R14 continued to remove the lap buddy according to the progress notes. On 5/18/16 at 8:22 PM, E8 LPN documents in the progress notes "very restless this shift, continuously taking off lap buddy and trying to "get out of here."

On 5/21/16, at 1900 (7:00 PM), Progress notes by E15 document "Resident found sitting on floor

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mat, beside bed in her room. sitting on buttocks, knees drawn up in front of her. lap buddy beside resident. examined for injury, none found. resident can move all extremities without pain. returned to wheelchair with help of two staff members, lap buddy replaced." The investigation report documents no interventions were added to the Care Plan and/or Kardex and conclusion documented as "poor safety awareness/perceives abilities greater than actual."

On 5/30/16 at 6:12 AM, R14 had another fall witnessed by E16, LPN, who documented "resident fall appears to be due to aid turning away while resident was with out her lap buddy staff made aware that resident needs monitored while in chair without lap buddy." E13, LPN document in the progress notes that R14 sustained "0.5 cm x 1 cm skin tear to left elbow." No investigation was done and no interventions were added to R14's Care Plan or Kardex in response to R14's fall.

On 6/28/16, at 8:15 AM, R14 was in the front hallway in her wheelchair. She had her purse open and dropped items from her purse onto the floor in front of her. R14 made several attempts at leaning over to pick them up off the floor, then unhooked the right side of her lap buddy leaning forward before staff reached her. She had a chair alarm clipped onto her shirt with a long cord to the unit. She had no wedge in her chair.

On 6/29/16 at 10:15 AM, E2 Director of Nurse (DON) acknowledged that R14 frequently removes her lap buddy and "quite often, which is okay because it gives staff a little more time to get to her." E2 stated after the first fall, they put an alarm on her but haven't put an additional

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interventions in place since the lap buddy. E2 stated CNAs know how to care for R14 from the Kardex available on the floor and states she has not had time to review those since becoming the DON in January, 2016. E2 also stated R14 doesn't have the front anti-tippers any longer because they were problematic from the start.

On 6/30/16 at 9:45 AM, E11 and E9, CNAs, confirmed R14 does not have a wedge in her wheelchair but does have a lap buddy and a chair alarm. E11 stated R14 will get "fidgety" when having to use the bathroom so you need to watch her for that. Both CNAs stated R14 can remove the lap buddy and does so many times on some days. E11 stated R14 is unable to use her call light due to her confusion and giving verbal reminders would not help or work due to her confusion.

On 6/30/16 at 10:10 AM, E16, LPN stated R14 is not able to use call light due to cognitive impairment but will tell you when she has to toilet, then off comes the lap buddy. E16 stated you would not be able to remind her of safety measures either.

The Kardex (undated) identifies R14 as "high risk", position changes with one staff but fails to identify her use of the lap buddy or her ability to remove it. The care plan hasn't been revised since 4/18/16 ever though she's had 3 additional falls and still includes the anti-tipper and the wedge cushion which she no longer has on her wheelchair. The falls prevention plan fails to identify that R14 frequently removes her lap buddy and does so at times when she has to use the toilet. The care plan includes ineffective interventions given R14's severe cognitive impairment such as call light in reach, educate

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resident about safety measures, verbal reminders to not lean forward too far for items that are out of reach.

The facility's policy/procedure (undated) documents its policy as "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." The one page policy documents under "Prioritizing approaches to manage falls and fall risks", it documents "the staff, with input of the attending physician, will identify appropriate interventions to reduce the risks of falls, if a systematic evaluation of a residents fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i. e. to try one or a few at a time, rather than many at once." The policy also documents "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicates why the currant approach remains relevant." The policy also documents if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions to try to minimize serious consequences of fall. Under "Monitoring Subsequent falls and fall risk," it documents staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." The policy documents the staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.

8. The MDS dated 5/3/16 identifies R5 was admitted on 6/17/14 and has severe cognitive impairment. The MDS documents R5 is totally

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dependent on 2 staff for transfers and has a restraint as a lap top table on his wheelchair. The Kardex, dated 10/28/15, documents R5 transfers with gait belt and 1-2 assists, and has a seat belt on. The Care Plan, dated 5/10/16, documents R5 includes two transfer directives: 1) requires extensive assistance by 2 staff to move between surfaces depending on residents functional status at the time (may require sit to stand) dated 2/24/16 and 2) The resident requires Mechanical sit to stand with 2 staff assistance for transfers for resident is unable to stand for 2 assists with gait belt. Staff are to "encourage the resident to participate to the fullest extent possible with each interaction." The care plan also documents R5 to use a three point chair due to poor trunk control, poor positioning and poor posture.

On 6/21/16 at 11:34 AM, E3 and E4, CNAs, were at R5's bedside and asked if he was ready to get up for lunch. E3 then pulled the covers down and grabbed him by the back of the neck while E4 swung his feet off the bed to side on the edge of the bed. R5 appeared stiff. E3 then applied a gait belt about his waist and then each CNA grabbed the gait belt under his arm and pulled him to a standing position as they swung him toward the reclining chair dropping him in the seat. R5 was not given the opportunity to stand up straight nor was he cued and/or encouraged to participate in the transfer by cueing him to stand up and move his feet. As R5 was turned to sit in his chair, his feet slid with no steps taken to the chair. E4 stated "He's so tired all of the time."

On 6/22/16 at 9:45 AM, R5 was in his room at bedside when E11 and E17, CNAs, entered the room with the mechanical sit to stand machine. Staff directed him to place his hands on the lift bars and attached the strap about his wait. R5

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was pulled up into a standing position and moved to the bed safely.

On 6/29/16 at 1:25 PM, E2 stated residents are assessed for safe transfers during the first few days by E7 Certified Rehab Aide (CRA) taking into account how they transferred at the last place they were. E2 also stated the transfer technique would be listed on the Kardex which she hasn't had a chance to update since she started as DON in January 2016. When asked what staff do if two different types of transfers were listed, E2 stated they assess the resident at the time in terms of how much assistance they needs.

On 6/30/16 at 10:50 AM, E7, CRA, was asked if she assessed residents for safe appropriate transfers stated she "looks at each resident when they are admitted to the facility and sees what how they transferred before" but doesn't evaluate them after that. E7 stated she does it verbally and has no documentation on it.

9. The MDS dated 5/5/16 documents R1 to have been admitted to the facility on 4/22/16. The MDS documents R1 to have severe cognitive impairment and require extensive assist of two staff for transfers. There is no fall risk assessment done. The MDS indicates she is unable to balance for transfers without staff assistance. The Care Plan, dated 4/29/16, documents R1 to be at high risk for falls due to unaware of safety needs and confusion. The Goal is to be free from falls. Interventions include anticipating/meeting needs, be sure residents light is within reach and encourage the resident to use to it for assistance, and educate the resident/family/caregivers about safety reminders and what to do if falls occur. There is nothing in the care plan regarding transfers and there is no

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Kardex for R1 in the book for CNAs to use as directives when providing care.

On 6/21/16 at 1:25 PM, E8 (LPN) and E9 (CNA) applied a gait belt and pulled R1 in a standing position. R1 had regular socks on and as she remained bent at the waist, E8 and E9 pivoted R1 around to sit on the recliner. Her feet did not move nor did she participate in the transfer. R1 was then lifted up in the recliner by E8 and E9 pulling her up in the chair under her arms and using the gait belt. R1's feet were dangling off the recliner when E9 stated "the chair is broke and won't recline." R1 was left in the recliner without support to her feet.

On 6/22/16 at 3:05 PM, E3 and E9, CNAs, applied a gait belt around R1's waist and stood R1 up from the recliner, pivoted her to sit in the wheelchair. Her feet did not move and she was not bearing weight. She was wearing regular socks. E3 and E9 then moved R1's chair to the bedside and they each grabbed the gait belt with one hand and the other placed under R1's arm. They lifted R1 up onto the mattress using the gait belt around her waist. R1 did not bear weight during this transfer.

On 6/30/16 at 10:50 AM, E7 stated she had not done an assessment on R1 but had only looked at her transfer on admission.

On 6/30/16 at 1:30 PM, E2 stated it is the policy of the facility for all pivot transfers be done with a gait belt. E2 stated all staff are provided a gait belt upon hire and are expected to use them accordingly.

The policy entitled "Transfer Activities" (undated) documents the purpose is to "transfer the

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resident from bed to chair, toilet or tub safely." The general guidelines include knocking and closing door, explain the procedure to the resident, explain safety measures to resident along with effects and/or complications, place call light in reach, screen for privacy in part. Equipment includes appropriate size chair, mechanical lift, pressure reducing devices as necessary, positioning devices as necessary and appropriate seat belts if necessary. The policy does not include procedures for transfer nor does it include the use of the gait belt.

On 6/29/16 at 9:20 AM, Z1, Medical Director (MD) stated he has discussed falls with the Administrator and DON before and suggested using a large spread sheet on the wall where they could all see the information when discussing fall issues. Z1 stated he was aware that falls occurred in the facility and has discussed individuals but not policies/procedures or systems for falls prevention since he's been MD. Z1 said if system problems were identified, developing protocols would raise the standard of care.

10. On 6/22/2016 at 9:05 AM R10 was sitting in a reclining chair and E11 Certified Nurse Aide (CNA) and E17 CNA put a gait belt around R10's trunk to transfer R10 to bed. E11 and E17 had a hand hold on gait belt and under R10's upper arm and transferred R10 into bed. R10 had only regular socks on and her feet did not touch the floor suspending her weight with the gait belt. No support was provided to the lower extremities during the transfer.

On 6/22/2016 at 12:23 PM, E11 and E17 entered R10's room to get her up for lunch. A gait belt was applied around R10's trunk and R10 was assisted to sit on side of bed with just sock on

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R10's feet and feet not on floor. E11 and E17 grabbed gait belt and upper arm and transferred R10 into a reclining chair. R10's feet again was not touching floor during the transfer again suspending all her weight on the gait belt. No support was provided to R10's lower extremities during the transfer.

On 6/22/2016 at 9:15 AM, E11 was asked if R10's feet were on floor and if she was bearing weight. E11 stated R10 is on hospice, doesn't stand and is contracted. E11 continued to state "We just lift her as she is not heavy."

Care Plan Revision dated on 04/01/2016 documents TRANSFER: "The residents requires Mechanical Lift Sit to Stand with 2 staff." The Morse Fall Scale, dated 3/28/2016, documents score of 75 with scoring of High Risk documents score of high risk of 45 and higher. R10's Kardex, updated 11/25/2014, documents "sit to stand for transfers."

(A)
Licensure 2 of 3
300.610a)
300.1210b)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.

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The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.
Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

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Based on observation, record review and interview, the facility failed to identify, assess, monitor, treat and provide repositioning to prevent pressure ulcers for 4 of 9 residents (R1, R2, R5 and R10) reviewed for pressure ulcers in the sample of 12, and one resident (R13) in the supplemental sample. This failure resulted in R2 developing three facility acquired Stage II pressure ulcers on the buttocks and R1 having a decline in a Stage IV pressure ulcer.

Findings include:

1. On 06/21/16, at 9:15 AM, R2 was sitting in a wheelchair in the TV room during an activity. At 11:15 AM, R2 was sitting in the wheelchair at the 200 hall nurse's station. At 11:30 AM, R2 was taken via wheelchair by E26, Certified Nurse's Aide, CNA, to the dining room for the lunch meal service. R2 remained in her wheelchair in the dining room from 11:30 AM to 1:30 PM without benefit of repositioning based on 15 minutes or less observation intervals. At 1:30 PM, E2, Director of Nurse's, DON, and E23, Licensed Practical Nurse, LPN, transferred R2 from the wheelchair to toilet, from toilet to wheelchair and from the wheelchair to bed. R2's buttocks were reddened with deep creases, as were the back of her thighs with a foul smell of urine. Observation of R2's entire buttocks was not possible due to multiple areas of skin folding over and R2 was very agitated. There was no dressing present when incontinent brief was removed. E2 stated R2 had no open areas on R2's bottom. R2 was very agitated and anxious and would not allow a complete skin check to be done.

On 06/22/16 at 8:00 AM, R2 was sitting in her wheelchair at the dining room table. At 8:50 AM, E25, Activity Aide, took R2 in her wheelchair to

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the TV room adjacent to the dining room. At 9:10 AM, E26 took R2 via wheelchair to R2's room for podiatry appointment. E26 did not offer to toilet R2, did not check R2 for incontinence or reposition R2. At 10:15 AM and 10:30 AM, R2 remained in the same position in her wheelchair. At 11:00 AM, E12, CNA, and E26 gave R2 incontinent care. R2 was saturated with urine through the incontinent brief, through her pants and onto the wheelchair cushion. There was no dressing present when the incontinent brief was removed. There were small pieces of the saturated incontinent brief observed throughout the front perineal area and the buttocks. E26 performed perineal care with wet wash cloth sprayed with peri wash with one wipe on each outer side of the labia, folding the cloth over between each wipe and then down the middle between the labia. R2's labia was deeply reddened with deep creases. R2 was then rolled to the right side and an additional wet wash cloth was used to wipe down between the buttocks and folded over wiping each buttocks with back and forth method due to small pieces of the incontinent brief remaining stuck to R2's buttocks. During this time, R2's buttocks remained deeply reddened with deep creases. There were two open areas identified on the right buttocks, one approximately 2.0 centimeters (cm) x (by) 3.0 cm and the second approximately 1.0 cm x 1.0 cm. Another open area identified on the left buttocks in between the gluteal fold approximately 1.0 cm x 2.0 cm. Both E12 and E26 stated that they had not seen these open areas before. E29, LPN was present in the room during this time but did not assist with care. E29 stated that she was not aware of any open areas on R2, and stated they looked to be staged at a level II. E29 did not assess these areas and stated to put some barrier cream on them. E26 pulled out the

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nightstand drawer an open cup of barrier cream, no lid or cover, and applied to R2's bilateral buttocks . R2 was then transferred back to the wheelchair. At that time, E12 and E26, both stated that R2 had been up since the night shift, because she was already in her wheelchair when they got to work around 6:00 AM. They both denied toileting her or repositioning her until 11:00 AM.

On 06/23/16 at 1:30 PM, E16, LPN, was observed during dressing change, however when surveyor entered R2's room, R2's pants and incontinent brief had already been removed. No dressing was present. E16 stated that barrier cream had been applied to R2's bottom. E16 then stated she had already cleaned R2's bottom with wound cleanser and had cut the gel-filled dressings (Duoderm) and dated them prior to the surveyor entering the room. E16 did not take any measurements, applied the dressings to each open area and covered R2 with a blanket. No incontinent brief was applied.

R2's Physician's Order Sheet, POS, dated June 2016, documented R2 had the following diagnoses, in part as, Muscle Weakness, Alzheimer's disease, Dementia with behavioral disturbances, Diabetes Mellitus, Anxiety Disorder and Pseudobulbar Affect. The POS, dated 06/14/16, documented an order for R2 for two areas one on the left buttock, measuring 2.0 cm x 3.0 cm x 0.1 cm and one area on the right gluteal fold, measuring 2.0 cm x 1.8 cm x 0.1 cm. It documented areas cleansed with wound wash, pat dry and apply Duoderm to be changed every three days and as needed until healed. The POS, dated 06/16/16, documented R2 had an order for a special gel-filled dressing (Duoderm) to left buttock and right gluteal fold wound.

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The Wound log, dated 06/14/16, documented the same measurements as listed above and those are the only measurements documented by the facility regarding R2's pressure ulcers. It also documented that these wounds were caused by R2 scratching herself and were acquired in house.

R2's MDS, dated 04/27/16, documented R2 was severely cognitively impaired with a BIMS score of zero and short and long term memory deficit. R2's MDS documented she had no pressure ulcers. It documented R2 required total assistance of at least one staff for bed mobility, transfers, locomotion in wheelchair, dressing, eating, hygiene and bathing. It also documented R2 required total assistance of two staff for toileting, was frequently incontinent of both bowel and bladder and had limitations of ROM of both upper and lower extremities.

The Care Plan, dated 04/14/16, documented R2 was dependent on staff for all Activities of Daily Living (ADL's) and totally dependent on staff for turning and repositioning, bathing, bed mobility, dressing, hygiene and transfers. It documented R2 was incontinent of both bowel and bladder and was identified as being moderately at risk for developing pressure ulcers.

The Braden Scale for the Development of Pressure Ulcers, dated 05/05/16, documented R2 scored 12 indicating high risk.

On 06/23/16 at 10:50 AM, E12 stated that she had provided care to resident that morning and there was no dressing present on R2's bottom only barrier cream. E12 stated that R2's open areas may not have required a dressing.

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On 06/23/16 at 10:56 AM, E16 stated that she did not know if R2 had a dressing on or not. E16 stated that E2 would know more because she does all of the measurements and keeps a log.

2. On 06/21/16 at 11:00 AM, R13 was sitting in a wheelchair in the TV room at an activity. At 11:35 AM, E9, CNA too R13 from the TV room directly to the dining room for the lunch meal service. E9 did not offer to toilet or reposition R13. R13 was in the dining room in her wheelchair until 1:30 PM when E9, CNA took her to her room and left her sitting in the wheelchair.

R13's POS, dated June 2016, documented R13 had the following diagnoses, in part as, muscle weakness, ataxic gait, cerebral infarction, urinary incontinence, colitis and gastroenteritis.

The MDS, dated 05/16/16, documented R13 was moderately cognitively impaired and required total assistance of one staff for bed mobility, transfers, locomotion, ambulation, bathing and toilet use. It documented R13 had ROM limitations in both the upper and lower extremities and was frequently incontinent of the bladder.

The Care Plan, dated 02/11/16, documented R13 was identified as being aphasic and incontinent of both bowel and bladder.

3. R1's MDS, dated 5/5/16, documents R1 as being admitted to the facility on 4/22/16 with bilateral unstageable heel pressure ulcers.

R1's Care Plan, dated 5/10/16, documents R1's heel ulcers are due to decreased mobility with the goal being to show signs of healing and have no new ulcers develop. Interventions include

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"Administer treatments as ordered and monitor for effectiveness, educate resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirement; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, following policies/procedures for prevention and treatment of pressure ulcers, monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (Sign/symptoms) of infection, wound size (length x width x depth), stage. Cushion to wheelchair and recliner, and layover on bed."

R1's Braden Scale, dated 4/29/16, documents R1 at moderate risk for pressure ulcers even though she was admitted with two unstageable ulcers of her heels.

R1's Laboratory results, dated 6/2/16, document low levels of Total Protein at 5.3 (normal 6-8.3) and Albumin 3.4 (normal 3.5-5.5).

R1's POS documents an order, dated 5/26/16, to "wash wounds, pat dry et (and) apply thin (hydrocolloid) every 3 days to Right buttock wound."

The first documentation of R1's heels on the Facility's Weekly Wound log is dated 4/30/16, 8 days after admission. Measurements being: right heel - 2 cm x 1.9 cm, unstageable, necrotic tissue 100% treated with skin Prep TID (three times daily), left heel - 3.8 cm x 3cm, unstageable, necrotic 100%, Skin Prep TID.

The Weekly Wound Log Assessment on 5/7/16 lists the same measurements and status for both heels. On 5/14/16, R1's right heel appears slightly larger at 3.0 cm x 1.9c, necrotic tissue

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100% with Skin Prep tid with no status/documentation on the left heel. On 5/21/16, R1's right heel measures 2.0 cm x 1.0 cm with less necrotic tissue at 25%, and left heel 3.8cm x 2.9cm 100% necrotic tissue again with both heels treated with skin prep TID. On 5/28/16, R1's right heel measured slightly larger at 2.0cm x 1.9cm again with 100% necrotic tissue treated with Skin Prep TID and the left heel 3.8cm x 3.0cm 100% necrotic with a treatment change to a hydrocolloid dressing every three days.

R1's May 2016 TAR does not include the Skin Prep to R1's heels.

Progress Notes documented by E10, Registered Nurse, RN, dated 5/26/16 at 16:14 (4:14pm) document "Staff brought to writers attention an open area to Rt (right) buttock during PM cares in res (resident) room. Measured it to be 1.5cm x .5cm - wound cleaned with wound cleanser and dry gauze applied until further notice." At 4:45 PM, a Physician's Order for a hydrocolloid dressing was given to be changed every three days.

On 5/28/16, two days later, on the Weekly Wound Log, R1's right buttock measured 5.2 cm x 3.8 cm x 0.1 cm depth, stage III with granulation and 50% slough/attached with a hydrocolloid dressing every three days. There is no documentation justifying this decline or why it wasn't identified earlier than the weekly assessment.

On 6/4/16, the weekly pressure ulcer log documented the right buttock as 2.2 cm x 2.0 cm x 0.1cm stage II, with granulation. The left heel measurements remained the same and the right heel showed some improvement with a slight decrease in size to 2.0 cm x 1.6cm with

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granulation and no necrosis documented for either heel wound.

On 6/18/16, R1 was documented as having another new pressure ulcer on her coccyx that measured 2.0 cm x 1.5 cm x 0.1 cm 90% slough no stage, right buttock back to stage III measuring 2.4 cm x 1.8 cm x 0.1 cm. Order for both was hydrocolloid dressing every three days. R1's left heel measured 3.8cm x 3.0cm x unstageable and right heel 2.0 cm x 2.4 cm unstageable, both with necrosis 100% which is inconsistent with the previous week.

On 6/21/16 at 3:05 PM, E3 and E9, CNAs, transferred R1 to her bed from the recliner. R1's hydrocolloid dressing dated 6/20 that was on her buttocks was loose on three sides, exposing the wound base which appeared very sloughy. There were two separate pressure ulcers, one on her left center buttocks and one on her right buttocks. E2 pulled the dressing off and after E3 and E9 cleansed R1's buttock/rectal area with a wash cloth, applied a new hydrocolloid dressing on the areas without first cleansing them.

Treatment Administration Records (TAR) for June 2016 document R1's dressing was initialed as changed on 6/19/16, not the 20th as documented on the dressing and no initials as done on 6/21/16 as observed by E2.

On 6/23/16 at 10:31 AM, E10 was asked if he had checked R1's coccyx dressing yet and stated "No." E4, CNA, was standing next to R10 and was asked if she had noticed if the dressing was intact when she last care for R1 and replied "It probably needs to be changed." R1's dressing was crumpled up and loose, hanging by a corner with the entire two wound bases exposed. Both

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	IL6006811	A. BUILDING: _____ B. WING _____	C 07/12/2016

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S9999	Continued From page 37 wound beds were sloughy and larger than when observed on 6/21/16. E10 replaced the dressing. As of 6/28/16, the June 2016 TAR did not have E10's initials as the treatment being done on 6/23/16. The facility's policy entitled "Pressure Ulcer, Care and Prevention of," undated, documents the purpose of the policy is to provide a "systematic approach in the prevention and healing of pressure ulcers" and "to prevent and treat further breakdown of pressure areas." The definition of pressure ulcer is "area of skin redness or breakdown caused by pressure to the area." The statement documents "All residents admitted to this facility will have a complete skin assessment with documentation of any known or potential risks that will place residents in danger of skin breakdown. Skin assessment weekly for the first 4 weeks, then quarterly and at time of significant change of condition." The policy documents "An individualized treatment plan for the prevention of skin breakdown and/or treatment for any existing pressure areas will be developed. When a pressure area is identified, an aggressive treatment program will be instituted and closely monitored to promote healing." Under procedure, staff are document ulcers upon identification and assessment. The policy documents all areas will be charted on daily. Nursing measures to be implemented include avoid friction/shearing when moving resident in bed, inspect sites of breakdowns as least during each nursing shift, cleanse skin at time of soiling, frequently change positions of immobile resident at least every two hours or as needed, and use pressure ulcer reducing devices in part. The policy includes a Skin Check Worksheet for the nurse and a CNA's Skin Assessment.	S9999		

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4. R5's MDS, dated 5/3/16, documents R5 has severe cognitive impairment and is totally dependent on staff for all activities of daily living (ADL's) except eating. The MDS documents R5 is always incontinent of bowel and bladder.

R5's Care Plan, dated 5/10/16, documents R5 has a potential for impairment to skin integrity r/t (related to) fragile skin and diabetes. The goal is to be free from injury through the next review with interventions being follow facility protocols for treatment, identify/document potential causative factors and eliminate/resolve where possible. Under Incontinence, the care plan interventions include clean peri-area with each incontinence episode, Wash/rinse/dry perineum, change clothing PRN (as needed) after incontinent episode in part.

On 6/22/16 at 9:45 AM, R5 was transferred to bed from his wheelchair by E17 and E11 CNAs. R5's incontinent paper brief was wet with urine and he had severe excoriation along with deep creases throughout his hips, buttocks and upper thighs. E17 provided poor incontinent care. E17 was asked how long R5 was in his wheelchair and replied he was up at 6:50 AM.

A Progress Note, dated 7/6/16 documents R1 was seen by Z1, Medical Director. The note documents Ulcer Left Buttocks Stage IV, refusing to eat/drink, Hospice services recommended. The Note also documents family agrees for wound care.

5. 6/21/2016 at 9:18 AM E8, LPN, stated R10 had a Duoderm film dressing on left hip for protection as R10's pressure area was healed.

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On 6/22/2016, from 9:15 AM until 12:23 PM, R10 was lying on her left side in bed based on 15 minutes or less observation intervals. At 12:23 PM, E11 and E17 was going to get R10 up for lunch. When E17 repositioned R10 to change her adult diaper, R10 had a duoderm film over her left hip dated 6/21/16. The Duoderm appeared dry with scar tissue under.

Facility Ulcer List, dated 6/17/2016-6/18/2016 documents the date R10's pressure ulcer was first observed as 06/26/2016. R10's Stage II pressure ulcer measured 1.0 cm by 1.4 cm by 0.1 cm.

On 7/4//2016 at 3:10 PM E2 brought in Pressure Ulcer List, dated 7/4/2016, with R10 current pressure ulcer measurements of 2.5 centimeter (cm) by 0.9 cm by 0.1 cm.

R10's Kardex , updated on 11/25/15 documents "stay off left hip turn and reposition every one hour."

PRESSURE ULCER, CARE AND PREVENTION OF; undated policy. POLICY STATEMENT documents "An individualized treatment plan for the prevention of skin breakdown and /or treatment for any existing pressure areas will be developed."

(B)
Licensure 3 of 3
300.610a)
300.1210b)
300.1210b)3)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and

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procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.
Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

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These requirements were not met as evidenced by:

Based on interviews, observations and record review, the facility failed to identify, assess and provide treatment for Range of Motion (ROM) deficits for 4 of 6 residents (R1, R2, R3 and R5) reviewed for ROM in a sample of 12 and one resident (R13) in the supplemental sample. This failure resulted in decline of ROM for R5.

Findings include:

1. R5's Minimum Data Set, MDS, dated 10/27/15, documents R5 to have no ROM deficits. R5's MDS, dated 2/1/16 documents limitations bilaterally upper and lower extremities with no services provided. The Minimum Data Set (MDS), dated 5/3/16, documents R5 has severe cognitive impairment and is totally dependent on staff for all activities of daily living (ADL's) except eating. The MDS documents R5 has range of motion limitations of upper and lower bilateral extremities. The MDS also documents R5 does not receive any range of motion services to meet these needs.

R5's Care Plan, dated 5/10/16, does not address R5's ROM limitations.

On 6/21/16 at 11:34 AM , E3 and E4, Certified Nurse's Assistants, CNAs, applied a gait belt around R5's waist and transferred R5 to his wheelchair. During the transfer, R5 remained bent at the knees as he was transferred to the wheelchair.

On 6/23/16 at 8:15 AM , E2, Director of Nurses (DON) stated R5 had an overall decline in general condition beginning in February 2016 and

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noted in May 2016 when asked about the decline in range of motion. E2 stated the decline was attributed to progression of his disease.

A Restorative List, provided by E7, Certified Rehab Aide (CRA), on 6/24/16, included residents receiving Passive Range of Motion (PROM), Active Range of Motion (AROM), and restorative programs. R5's name was not included on this list. The list documented a total of 5 residents receiving services.

On 7/1/16 at 9:45 AM, when asked how the facility determines who gets range of motion, E7 stated she "looks at the residents on admission and sees what they can do." E7 stated the facility only does restorative and doesn't do any assessment toward measuring actual limitations by degrees.

The facility's policy entitled "Rehabilitation: Range of Motion (active, active assistance, and Passive)," undated, documents the purpose as "1. to move the residents joints through as full a range of motion as possible, 2. to improve or maintain joint mobility and muscle strength, 3. to prevent contractures, 4. to increase strength and activity tolerance, 5. to reduce pain, 6. to prevent complications of mobility. The policy continues to document the procedure of range of motion exercises but fails to include assessments of limitations for residents at risk for contracture and for those who currently have contractures to ensure services are provided when needed."

2. The MDS, dated 5/5/16, documents R1 as being severely cognitively impaired and admitted to the facility on 4/22/16 with bilateral limitations to upper and lower extremities.

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R1's Care Plan, dated 5//10/16, did not address any ROM services or R1's limitations in ROM.

The Restorative List that includes residents receiving PROM/AROM documented R1 was receiving PROMs to her upper and lower extremities.

The Restorative Therapy Record, written by E7, documents on 5/24/16 that she did "PROM with resident and only did 3 repetitions each, resident was very stiff, will have to go slow with her." On 5/26/16, E7 documented "worked on arms today to see if I can get more extention to help her with eating." On 5/27/16, E7 documents "did want to eat good today on her own, try to her to use her arms + hand to help herself. She said no." E7's next note was dated 6/6/16 and documents R1 "did all PROM with U (upper) + L (lower) extremities, resident was very resistant, was able to do some stretches." E7's 6/11/16 note documents, "Did PROM resident was not wanting me to do much, worked mostly with U extremities." On 6/14/16, E7 documented "Resident was good with U extremity ex (exercises) today" and on 6/20/16, E7 documented "Resident did better today did U + L ex it is all PROM."

On 6/23/16 at 10:45 AM, E7 was asked to do PROM on R1 who was in bed at the time. E7 replied that she would wait until they got her up in the wheelchair to do ROM. At 11:20 AM, E7 propelled R1 into the therapy room to do PROMs. R1 remained in her wheelchair. E7 did Flexion/extension and horizontal abduction/adduction on R1's shoulder but failed to do abduction/adduction, Internal/external rotation and hyperextension for the shoulder joint. No elbow joint exercises were done. E7 did

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flexion/extension/hyperextension on R1's wrist joint but failed to do ulnar/radial deviation or circumduction exercises. No finger joint exercises were done but flexion/extension of the thumb joint was done. No abduction/adduction or opposition of the thumb joint was done. E7 did flexion/extension of R1's hip joint but no abduction/adduction, internal/external rotation or hyperextension of the hip joint was done. E7 failed to do inversion/eversion of the ankle joint and no toe joint range of motion was provided.

E7 stated on 6/23/16 at 10:45 AM, that R1 receives ROM 5-6 times per week and that she is the only staff member that does the facility's ROM exercises. E7 stated there are no assessments as to the degree of limitations for R1.

On 6/29/16, Z1, Medical Director, stated he would expect staff to complete PROM procedures properly and for the residents that require it.

On 7/7/16 at 11:30 AM, Z3, Nurse Consultant, stated that standard practice of range of motion would be for it to be done twice daily 7 days a week.

3. On 06/29/16 at 2:15 PM, E14, CNA stated that the CNA's do not do PROM's on residents and that E7, Rehab Aide was responsible for doing restoratives for residents. E14 stated she was not sure which residents were on restorative programs. E12, CNA was in the hall at this time and heard the conversation, and conferred with E14 that CNA's do not do the ROM for the residents.

The MDS, dated 04/27/16, documented R2 was severely cognitively impaired with both short and long term memory deficits. It documented R2

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required total assistance of at least one staff for bed mobility, transfers, locomotion, dressing, eating, hygiene and bathing. It documented R2 was identified as having ROM limitations in both the upper and lower extremities.

The Restorative list provided on 07/01/16 by E7, Rehab Aide, documented R2 was to receive PROM's on both upper and lower extremities.

The facility had no documentation R2 had received any PROM.

4. On 06/21/16, during tour of the 200 hall, R13 had contractures of both hands and both feet. There were no splints, braces or anti-contracture devices in use.

The MDS, dated 05/16/16, documented R13 was moderately cognitively impaired and required total assistance of at least one staff for bed mobility, transfer, ambulation, locomotion, bathing and toilet use. It documented R13 had limitations in both the upper and lower extremities and was on a restorative program for PROM's for seven days per week.

The Restorative list of residents presented on 06/24/16 by E7 did not include R13 for receiving any type of restorative services.

The Care Plan, dated 02/11/16, documented R13 had limited physical mobility.

There was no documentation provided by the facility that R13 received PROMs or that a comprehensive assessment had been conducted that assessed R13's ROM limitations or contractures.

5. On 6/24/2016 12:10 PM E11, CNA, went into

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R3's room and assisted R3 to sit on the left side of the bed. E11 placed gait belt around R3's trunk and began ambulating R3 into bathroom. R3's knees were slightly bent with ambulation. Upon coming out of bathroom, E11 placed R3 into the wheelchair, removed the gait belt and propelled R3 into the dining room.

On 6/24/2016, at 12:20 PM, E11, CNA was asked if R3 walks to the dining room for lunch. E11 stated, "No." E11 stated R3 would get up too much and would go by self.

On 6/24/2016, at 1:50 PM, E3, CNA, was asked if R3 walked to lunch or was in wheelchair. E3 stated R3 went to lunch in a wheelchair.

On 6/24/2016, at 11:10 AM, E7 was asked about R3 walking. E7 stated she walks 100 to 120 feet for lunch and supper and R3 receives no range of motion.

R3's Care Plan Intervention/Tasks, revised on 2/1/16, documents "NURSING REHAB/RESTORATIVE: Transfer and walk resident to Lunch and Supper to maintain mobility."

R3's MDS, dated 10/20/15, documents R3 had no limitation in range of motion for lower and upper extremities. R3's MDS dated 02/01/2016 documents she had limitations on both sides of both lower and upper extremities.

(B)

IMPOSED PLAN OF CORRECTION
NAME OF FACILITY: Oak Terrace
DATE AND TYPE OF SURVEY: July 12, 2016 Annual Foss with Complaint# 1643667/IL86672 Licensure Violations

300.610a)
300.1210b)c)d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.*

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions. The assessments for all residents identified as high risk for injury as a result of facility failure to follow resident care planned safe transfer techniques will be reviewed and facility's policy will be revised as necessary based on the outcome of the review.

II. Nursing staff will be in-serviced on patient safety, care plans, and safe transfer techniques. The in-services will cover, at a minimum, accurate assessment and documentation of patient transfer technique in patient care plan, knowledge and implementation of patients care plan, follow-up of incidents identifying causative factors, resident changes or indicators that may require reassessment or other interventions to prevent injury.

III. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

IV. The Administrator and Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Corrections.

Attachment B
- Imposed Plan of Correction

IMPOSED PLAN OF CORRECTION
NAME OF FACILITY: Oak Terrace
DATE AND TYPE OF SURVEY: July 12, 2016 Annual Foss with Complaint# 1643667/IL86672
Licensure Violations

300.610a)
300.1210b)c)d)6)
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